APPLICATION FOR APPOINTMENT AS QUALIFIED MEDICAL EVALUATOR

For the Department of Industrial Relations
Industrial Medical Council
P. O. Box 8888
San Francisco, CA 94128-8888

FOR IMC USE ONLY
QME NO.:
INPUT DATE:
INPUT BY:

BLOCK 1 (FOR ALL APPLICANTS) PLEASE TYPE OR PRINT LEGIBLY

Please list your primary location. Additional locations may be added when your fee assessment is paid. You will be billed shortly after passing the QME test.

LAST NAME	FIRST NAME	MI	JR/SR

BUSINESS ADDRESS WHERE QME EVALUATIONS WILL TAKE PLACE
(DO NOT USE P. O. BOX)

MAILING ADDRESS FOR CORRESPONDENCE	CITY	ZIP + 4

(AREA CODE) PHONE NO.	CAL. PROFESSIONAL LICENSE NUMBER	EXPIRATION (MM/YY)	YEAR ENTERED PRACTICE

PROCEED TO BLOCK 2

BLOCK 2 (FOR ALL APPLICANTS) IMPORTANT: BLOCK 2 Must be fully completed before proceeding.

PROFESSIONAL EDUCATION {INDICATE DEGREE OBTAINED (e.g. MD, DC, DO, Ph.D, EDD, etc.)}

COLLEGE/UNIVERSITY/MEDICAL SCHOOL			
CITY	**STATE**	**DATE OF DEGREE**	**DEGREE**

If MD or DO, COMPLETE BLOCKS 3,6,7,8,9
If DC, COMPLETE BLOCKS 4,7,8,9
If PHD or EDD, COMPLETE BLOCKS 5,7,8,9
Other Degrees, COMPLETE BLOCKS 7,8,9

BLOCK 3 (FOR MDs AND DOs ONLY)

POSTGRADUATE TRAINING/EDUCATION:

NOTE: IF TRAINING WAS RECEIVED FROM A FACILITY/HOSPITAL OUTSIDE THE USA, PLEASE INDICATE BOTH CITY AND COUNTRY IN LOCATION BOX (DO NOT ENTER "SEE RESUME")

	Hospital/Facility	Location (City/State)	Type	Year From	Year To
INTERNSHIP:					
RESIDENCY 1:					
RESIDENCY 2:					
RESIDENCY 3:					
FELLOWSHIP:					

IMPORTANT: IF APPLICANT IS BOARD CERTIFIED, PLEASE PROVIDE COPY OF BOARD CERTIFICATE(S). OTHERWISE, PLEASE PROVIDE COPY OF CERTIFICATE(S) OF COMPLETION OF POSTGRADUATE TRAINING.

PROCEED TO BLOCK 6

BLOCK 4 (FOR DCs ONLY)
NOTE: APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS

	YES	NO
1) I am certified in California workers' compensation evaluation by either a California professional chiropractic association or an accredited California college recognized by the Council. (i.e. IDE Certificate (min. 44 hrs eff. 4/15/99)).	☐	☐
2) I have completed a chiropractic postgraduate specialty program of a minimum of 300 hours taught by a school or college recognized by the council, the Board of Chiropractic Examiners and the Council on Chiropractic Education.	☐	☐
3) I declare under penalty of perjury to the council that I wrote 100 or more ratable comprehensive medical-legal evaluation reports and served as an AME on 25 or more occasions during each calendar year between January 1, 1990, and December 31,1994. (Please provide documentation of 25 AMEs between January 1, 1994 and December 31,1994, i.e. AME cover letters or first page of the reports.)	☐	☐
4) I declare under penalty of perjury to the council that I have served as an AME on eight or more occasions prior to 1/1/70.	☐	☐

PROCEED TO BLOCK 7

BLOCK 5 (FOR PHDs AND EDDs ONLY)
NOTE: APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS

	YES	NO
1) I am board certified in clinical psychology by the American Board of Professional Psychology, Inc.	☐	☐
2) I have a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology, from a university or professional school recognized by the Industrial Medical Council and have not less than five years postdoctoral experience in the diagnosis and treatment of emotional and mental disorders.	☐	☐
3) I have not less than five years postdoctoral experience in the diagnosis and treatment of emotional and mental disorders and I have served as and (Agreed Medical Evaluator) AME or eight or more occasions prior to January 1, 1990. (Please provide documentation of 8 AMEs, i.e. AME cover letters, first page pf the reports, or a sworn statement made under penalty of perjury).	☐	☐
4) I declare under penalty of perjury to the council that I wrote 100 or more ratable comprehensive medical-legal evaluation reports and served as an AME on 25 or more occasions during each calendar year between January 1, 1990, and December 31,1994. (Please provide documentation of 25 AMEs between January 1, 1994 and December 31,1994, i.e. AME cover letters or first page of the reports.	☐	☐
5) I declare under penalty of perjury to the council that I have served as an AME on eight or more occasions prior to 1/1/70.	☐	☐

PROCEED TO BLOCK 7

BLOCK 6 (FOR MDs AND DOs ONLY)
NOTE: APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS

	T (True)	F (False)
1) I am board certified in the specialty for which I am applying to become a QME by a board recognized by the Council and the Medical Board of California or the Osteopathic Medical Board of California.	☐	☐
2) I am board qualified because:		
a) Since 1985, I have not failed the specialty certifying exam in the specialty for which I seek appointment as a QME; and	☐	☐
b) I have completed the minimum requirements as defined by a specialty board recognized by the council for postgraduate training in the specialty at an institution recognized by the ACGME or the osteopathic equivalent on _____. (Date Completed	☐	☐
3) I declare under penalty of perjury to the council that I wrote 100 or more ratable comprehensive medical-legal evaluation reports and served as an AME on 25 or more occasions during each calendar year between January 1, 1990, and December 31, 1994. (Documentation required).	☐	☐
4) I have qualifications that the Council and the Medical Board of California or the Osteopathic Medical Board of California both deem to be equivalent to board certification in a specialty. (Please submit documentation from the Medical Board).	☐	☐
5) I declare under penalty of perjury to the Council that I served as an AME on 8 or more occasions prior to 1/1/70.	☐	☐

PROCEED TO BLOCK 7

BLOCK 7 (FOR ALL APPLICANTS)

NOTE: APPLICANT MUST MEET ONE OF THE FOLLOWING REQUIREMENTS **YES** **NO**

1) I devote at least one-third of my total practice time to providing direct medical treatment ("Direct Medical Treatment" is that special phase of the health care provider-patient relationship which (1) attempts to clinically diagnose and alter or modify the expression of a non-industrial illness, injury or pathological condition; or (2) attempts to cure or relieve the effects of an industrial injury.) ☐ ☐

2) I have served as an Agreed Medical Evaluator (AME) on eight (8) or more occasions in the 12 months prior to submitting this application. (Submit documentation of 8 AME's, i.e. AME cover letters, first page of reports or a sworn statement made under penalty of perjury.) ☐ ☐

PROCEED TO BLOCK 8

BLOCK 8 (FOR ALL APPLICANTS)

PLEASE INDICATE SPECIALTY(IES) FOR WHICH YOU ARE APPLYING TO DO QME EXAMS (USE ENCLOSED SPECIALTY CODE LIST)

Professional practice specialty code: ☐ Professional practice specialty code: ☐ Professional practice specialty code: ☐

REMINDER: **COPY OF BOARD CERTIFICATE OR DOCUMENTATION THAT YOU ARE BOARD QUALIFIED (FOR DCs A CERTIFICATE FROM POSTGRADUATE SPECIALTY DIPLOMATE PROGRAM) MUST BE SUBMITTED FOR EACH SPECIALTY**

PROCEED TO BLOCK 9

A PUBLIC DOCUMENT

PRIVACY NOTICE - The Information Practices Act of 1977 and the Federal Privacy Act require the Industrial Medical Council (IMC) to provide the following notice to individuals who are asked by a governmental entityto supply information for appointment as a Qualified Medical Evaluator (QME).

The principal purpose for requesting information from QMEs is to administer the QME program within the California workers' compensation system. Additional information may be requested if your application is denied and/or a disciplinary action is taken.

The California Labor Code requires every QME physician to meet certain statutory requirements. Physicians are required by the Labor Code to provide: name; business address/addresses; professional education; training; license number; year entered practice and other requirements deemed necessary by the IMC. It is mandatory to furnish all the appropriate information requested by the IMC. Failure to provide all of the requested information may result in the denial of the application.

As authorized by law, information furnished on this form may be given to: you, upon request; the public, pursuant to the Public Records Act; a governmental entity, when required by state or federal law; to any person, pursuant to a subpoena or court order or pursuant to any other exception in Civil Code § 1798.24.

An individual has a right of access to records containing his/her personal information that are maintained by the IMC. An individual may also amend, correct, or dispute information in such personal records (Civil Code § 1798.34-1798.37).

Requests should be sent to:

Industrial Medical Council
P.O. BOX 8888
SAN FRANCISCO, CA 94128-8888
(650) 737-2700
www.dir.ca.gov

You may request a copy of the IMC policy and procedures for inspection of records at the above address. Copies of the procedures and all records are ten cents ($0.10) per page, payable in advance. (Civil Code § 1798.33).

BLOCK 9 (FOR ALL APPLICANTS)

INITIAL EACH BOX

AFFIRMATIONS: Initialling each box affirms that you have read and agree to each of the statements

A. I agree I will file my reports within the statutory time limits of the date I conduct my evaluation unless an extension of time is warranted and, if required, approved by the Executive Medical Director. ☐

B. I have read and understand Labor Code Section 139.3 and 139.31. I agree that I shall abide by all their provisions. I will not refer patients to facilities in which I or my family members have a financial interest, except as permitted by law. I agree I shall not offer, deliver, receive or accept any rebate, refund, commission, preference, patronage, dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred evaluation or consultation. I agree not to solicit to provide medical treatment to an injured employee for any injury for which I have done a QME evaluation. I have not committed a misdemeanor or felony related to my practice. I have not performed a QME evaluation while not certified by the IMC as a QME. ☐

C. I certify that I meet all standards of performance and conduct for QME appointment and I shall endeavor to continue to meet such standards during my term as a Qualified Medical Evaluator. ☐

D. I understand that I must keep my license to practice active and that it currently is active. I certify that I am not currently on probation with my licensing board nor on any court-ordered probation in connection with any conviction related to the conduct of my practice. I certify I will notify the IMC of any of the following events: a) change in my license status; b) any past or future conviction related to the conduct of my practice or for any crime of moral turpitude; and c) upon being placed on probation by my licensing board or by any court-ordered probation. ☐

E. I agree that all information provided in this application is public information and subject to statutes regarding medical-legal evaluation privacy and confidentiality. ☐

F. I agree that I shall not request or accept any compensation from any source for a comprehensive medical-legal evaluation in excess of fees authorized by the medical-legal fee schedule**.** ☐

G. I certify that all the information and supporting documentation which I previously submitted to the IMC with my earlier QME application(s) is bona fide, true and correct. ☐

VERIFICATION

I have used all reasonable diligence in preparing and completing this application. I have reviewed this completed application and to the best of my knowledge the information contained herein and in the attached supporting documentation is true, correct and complete. Failure to provide truthful information shall result in denial of applicant's appointment and/or disciplinary action. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on	**(MM/DD/YY)**	**at**	**County**	**CA**	**Applicant's Signature**

IMPORTANT: Application for appointment for QME may be returned if it is incomplete or is not submitted with the required supporting documentation. Please make sure that:

1) Application is fully completed, dated and signed with an original signature. We will not accept faxed applications. Please also submit statement of citizenship form.

2) All necessary documentation is attached:

   a) All applicants - Copy of current California Professional License.

   b) MDs, DOs - copy of board certification or certificate of completion of postgraduate training, as appropriate.

   c) DCs - certificate in California Workers' Compensation Evaluation or copy of certificate from postgraduate specialty diplomate program.

   d) PHDs and EDDs - copy of professional diploma. Copy of board certification, if appropriate.

   e) ALL OTHERS - copy of professional diploma

For Use on the QME Application Form

IMPORTANT: PLEASE USE THREE LETTER SPECIALTY CODE WHEN COMPLETING BLOCK 8 OF APPLICATION FORM

MD/DO SPECIALTY CODES

MAI Allergy and Immunology
MAA Anesthesiology
MRS Colon & Rectal Surgery
MDE Dermatology
MEM Emergency Medicine
MFP Family Practice - MD
OFP Family Practice - DO
OFM Family Practice - DO - Including Osteopathic Manipulation
MPM General Preventive Medicine
MOH Hand - Orthopaedic Surgery
MPH Hand - Plastic Surgery
MSH Hand - Surgery
MMM Internal Medicine
MMV Internal Medicine - Cardiovascular Disease
MME Internal Medicine - Endocrinology Diabetes and Metabolism
MMG Internal Medicine - Gastroenterology
MMH Internal Medicine - Hematology
MMI Internal Medicine - Infectious Disease
MMO Internal Medicine - Medical Oncology
MMN Internal Medicine - Nephrology
MMP Internal Medicine - Pulmonary Disease
MMR Internal Medicine - Rheumatology
MOQ Medicine - Otherwise Qualified
MPN Neurology
MNS Neurological Surgery
MNM Nuclear Medicine
MOG Obstetrics and Gynecology
MPO Occupational Medicine
MOP Ophthalmology
MOS Orthopaedic Surgery
MOB Orthopaedic Surgery - Including Back
MTO Otolaryngology
MAP Pain Management - Anesthesiology
MPP Pain Management - Pain Medicine
MHA Pathology
MEP Pediatrics
MPR Physical Medicine & Rehabilitation
MPS Plastic Surgery
MPD Psychiatry
MRY Radiology
MSY Surgery
MSG Surgery - General Vascular
MTS Thoracic Surgery
MPT Toxicology - Occupational Medicine
MET Toxicology - Emergency Medicine
MUU Urology

NON-MD/DO SPECIALTY CODES

*denotes a doctor of chiropractic who has completed a chiropractic post-graduate specialty program

ACA Acupuncture
DCH Chiropractic
DCN Chiropractic - Neurology*
DCO Chiropractic - Orthopaedic*
DCR Chiropractic - Radiology*
DCS Chiropractic - Sports Medicine*
DCT Chiropractic - Rehabilitation*
DEN Dentistry
OPT Optometry
POD Podiatry
PSY Psychology
PSN Psychology - Clinical Neuropsychology